Arrival Time _____ MRN _____

## Patient

| First Name | Last Name | MI | Date of Birth |
|---|---|---|---|
| Address | City | State | Zip |
| Home Phone | Work Phone | Cell Phone | |
| Other Name (s) Used | | Email Address | |
| Gender M F SS# | Driver's License | Preferred language | |

**Marital Status**
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

**Preferred Contact**
- ☐ Mail
- ☐ Home Phone
- ☐ Day Phone
- ☐ Cell Phone
- ☐ Patient Portal (My Chart)

**Ethnicity**
- ☐ Cambodian
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Non-Hispanic

**Race**
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

| Primary Care Provider | Reason for Visit | Referring Provider |
|---|---|---|

## Responsible Party (Guarantor)

| First Name | Last Name | MI | Date of Birth |
|---|---|---|---|
| Address | City | State | Zip |
| Home Phone | Work Phone | Cell Phone | |
| SS# Driver's License | Preferred language | | Relationship to patient |

## Emergency Contact (for minor child, this section may be used for other parent)

| First Name | Last Name | MI | Date of Birth |
|---|---|---|---|
| Address | City | State | Zip |
| Home Phone | Work Phone | Cell Phone | Relationship to patient |

I/we do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Churn Creek Healthcare to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsibility for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses and attorneys fees incurred to collect any amount I may owe. I also hereby authorize Churn Creek Healthcare to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

Signature of responsible party _____ Date _____

Name of patient/responsible party (please print) _____ Date _____

MRN

| Pharmacy Information | |
|---|---|
| Preferred Pharmacy<br>Name | Secondary Pharmacy<br>Name |
| Address | Address |
| Phone Fax | Phone Fax |
| | |

**ADVANCED DIRECTIVE**

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy ☐ POLST

Medications—List all medications you take, prescription and non-prescription and the dosage.
I do not take any medications

| Medication Name | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Medication and food allergies—List all known allergies (drugs) food, animals, etc ☐ No Known Allergies

Medical History—Check if you have ever experienced the following conditions and year of onset

| Condition | Year | Condition | Year |
|---|---|---|---|
| ☐ None | | ☐ Gallbladder disease | |
| ☐ Allergies | | ☐ GERD (Reflux) | |
| ☐ Anemia | | ☐ Hepatitis C | |
| ☐ Angina | | ☐ Hyperlipidemia | |
| ☐ Anxiety | | ☐ Hypertension | |
| ☐ Arthritis | | ☐ Irritable Bowel Disease | |
| ☐ Asthma | | ☐ Liver Disease | |
| ☐ Atrial Fibrillation | | ☐ Migraine Headaches | |
| ☐ Benign Prostatic Hypertrophy | | ☐ Myocardial Infarction | |
| ☐ Blood Clots | | ☐ Osteoarthritis | |
| ☐ Cancer—Type | | ☐ Osteoporosis | |
| ☐ Cerebrovascular Accident | | ☐ Peptic Ulcer Disease | |
| ☐ Coronary Artery Disease | | ☐ Renal Disease | |
| ☐ COPD (Emphysema) | | ☐ Seizure Disorder | |
| ☐ Crohn's Disease | | ☐ Thyroid Disease | |
| ☐ Depression | | ☐ Other | |
| ☐ Diabetes | | ☐ Other | |
| | | | |

Medical History—Check if you have ever experienced the following conditions and year of onset

| Surgical Procedures | Year | Surgical Procedures | Year |
|---|---|---|---|
| None | | **Male Only** | |
| ◯ Angioplasty | | ◯ Prostate Biopsy | |
| ◯ Angioplasty w/stent | | ◯ TURP (trans-urethral resection of prostrate) | |
| ◯ Appendectomy | | ◯ Vasectomy | |
| ◯ Arthroscopy knee | | ◯ Other | |
| ◯ Back Surgery | | ◯ Other | |
| ◯ CABG (heart bypass) | | **Female Only** | |
| ◯ Carpal Tunnel Release | | ◯ Augmentation Mammoplasty | |
| ◯ Cataract Extraction | | ◯ Bilateral Tubal Ligation | |
| ◯ Colecystectomy | | ◯ Breast Biopsy | |
| ◯ Colostomy | | ◯ Cesarean | |
| ◯ Gastric bypass | | ◯ D and C | |
| ◯ Hip replacement | | ◯ Hysterectomy | |
| ◯ Knee replacement | | ◯ Mastectomy | |
| ◯ LASIK | | ◯ Myonmectomy | |
| ◯ Liver biopsy | | ◯ Reduction Mammosplasty | |
| ◯ Pacemaker | | ◯ TAH/BSO | |
| ◯ Small bowel resection | | ◯ Vaginal Hysterectomy | |
| ◯ Thyroidectomy | | ◯ Other | |
| ◯ Tonsillectomy | | ◯ Other | |
| ◯ Tonsillectomy | | | |

Health Maintenance—Check if you received the following and the date of most recent exam

| ◯ Exam | Date | ◯ Exam | Date |
|---|---|---|---|
| ◯ None | | ◯ GYN Exam | |
| ◯ Breast Exam | | ◯ Influenza Vaccine | |
| ◯ Cardiac Stress Test | | ◯ Lipid Panel | |
| ◯ Colonoscopy | | ◯ Mammogram | |
| ◯ Dexa Scan | | ◯ PAP Test | |
| ◯ Echocardiogram | | ◯ Physical Exam | |
| ◯ EKG | | ◯ Pheumococcal Vaccine | |
| ◯ Eye Exam | | ◯ Pulmonary Function Test | |
| ◯ FOBT (stool card for hidden blood) | | ◯ Signmoidoscopy | |
| ◯ Foot Exam | | ◯ Tetanus Vaccine | |
| | | | |

Family History—Check if any family member(s) has had any of the following conditions.

◯ Adopted

| Diagnosis | Mother | Father | Brother | Sister | Other | Other |
|---|---|---|---|---|---|---|
| ◯ Alcoholism | | | | | | |
| ◯ Allergies | | | | | | |
| ◯ Alzheimer's Disease | | | | | | |
| ◯ Asthma | | | | | | |
| ◯ Blood Disease | | | | | | |
| ◯ CAD (Heart attack) | | | | | | |
| ◯ Cancer—Type: | | | | | | |
| ◯ CVA (stroke) | | | | | | |
| | | | | | | |

## Family History continued

| ◯ Adopted | | | | | | |
|---|---|---|---|---|---|---|
| Diagnosis | Mother | Father | Brother | Sister | Other | Other |
| ◯ Eczema | | | | | | |
| ◯ Hearing Deficiency | | | | | | |
| ◯ High Cholesterol | | | | | | |
| ◯ High Blood Pressure | | | | | | |
| ◯ Irritable Bowel Disease | | | | | | |
| ◯ Learning Disability | | | | | | |
| ◯ Mental Illness | | | | | | |
| ◯ Tuberculosis | | | | | | |
| ◯ Obesity | | | | | | |
| ◯ Osteoarthritis | | | | | | |
| ◯ Osteoporosis | | | | | | |
| ◯ PVD | | | | | | |
| ◯ Renal Disease | | | | | | |
| ◯ Other | | | | | | |

## Social History for Adult Patient

Occupation Employer

Do you have children? ◯ Yes ◯ No How many?: Female(s) Male(s)

Tobacco Use ◯ Y ◯ N ◯ Daily ◯ Weekly ◯ Less ◯ Chewing ◯ Pipe
Former/Year quit ◯ Cigar ◯ Cigarette
Smokeless Brand:

Alcohol Use ◯ Y ◯ N ◯ Daily ◯ Weekly ◯ Less ◯ Beer ◯ Wine ◯ Liquor ◯ Other

Exercise Activity ◯ Moderate ◯ Vigorous ◯ Sedentary ◯ Sleep Pattern Changes

Caffeine Use ◯ Daily ◯ Weekly ◯ Less Chocolate Coffee (please circle all that apply)
Soda Tea
Tablets Other:

## For Pediatric Patient

Patient resides with: Primary Mother Father Both Parents Other
(please circle all that apply) Secondary Mother Father Other:

Mother's Occupation _____ Father's Occupation: _____

Parents Relationship (please circle all that apply)
Married Single
Divorced Separated
Widowed

Childcare
Mother Grandparent
Father Nanny
Sibling Daycare

Tobacco Exposure Yes No Parent is current smoker ◯ Yes ◯ No
Smokers at home Yes No